An In-depth Review of the Human Perspective in Modern Society

——Medical Care Issues Considered as Human Rights Issues——

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This thesis was focused on an in-depth analysis of present problems in the field of medical care, especially on various issues related to human rights and welfare, in order to investigate "the human perspective in modern society."

I. Medical Treatment in Modern Society

The relationship between a patient suffering from an illness and the medical doctor conducting treatment in the search for a cure (the proprietor of diagnostic and treatment technique) can be categorized under the heading of "the origin of medical care."

Thus, our first task should be to confirm the concepts related to medical care and illness as well as the different types of rights related to health.

[1] The concept of medical care.

"Medical care" is considered to be the social application of medical science for the maintenance and improvement of the health of individuals. For example, according to Shigerist, medical care is fundamentally a social relationship. The origin and the central theme of this concept deals with two parties, a patient who has an illness or who is wounded and a physician who is conducting the diagnosis and treatment thereof, that is, the origin of this concept lays in the relationship between these two people, a manifestation of the true character of medical care.[1)]

Furthermore, in regard to the related subject of hygiene, the policies and efforts

related to hygiene (the whole range of health education and health preservation related activities) are all designed to maintain or improve "health." Thus the target and objective of hygiene is simply "health."

So, a physician should look not at a patient's illness, but rather at the ill patient, and not at a particular organ, but rather at the whole body. In this regard, respect for humanity and life itself must be the basis on which medical care is conducted. Looking at the patient as a whole being allows for the existence of comprehensive medical care. In addition, if medical science is limited to mere 'zoology' or the study of single organs (isolated scientific studies), it can only lose sight of "humanity." Thus the present age is one in which an assessment and analysis of this kind of modern medical care is essential.

[2] The concept of illness and health rights.

The definition of health according to the World Health Organization (WHO) does not limit that state to one free of illness or one in which the body is not weakened, but rather it includes the phase "complete well-being," used in a mental, physical, and social sense. Irrespective of the present state of human rights, religion, political situation, and the socioeconomic conditions in the various countries of the world, WHO is striving for enjoyment of the highest standards of health as a fundamental human right, on a unified global scale. This is the so-called subject of "health rights." The Japanese constitution also refers to "health rights" as a basic human right, a manifestation of the stress placed on this subject in Japan. In regard to declarations on human rights worldwide, health rights have been guaranteed both now and in the future and they are considered to be above violation.

Thus, at present, global standards are in demand for the formation of a society in which all people can live in health and enjoy life to its full extent, both subjectively and actively, and it cannot be forgotten that the improvement of the quality of living (QOL) is the fundamental concept behind this movement.

However, case by case, it can be considered that "health" is related to the following subjects: illness, symptoms, the existence or nonexistence of abnormalities,

1) Felix Marti-Ibanez(ed), *Henry E. Shigerist on the History of Medicine*, New York: M. D. Publications, 1960, P. 26.

life or existence, living (daily existence) and livelihood, lifetime or one's whole life span, control abilities, degree of independence and ability to execute everyday roles, degree of health and the grasp of the symptoms, judgement, the increase in the independence of patients or handicapped persons, attitude towards health activities and life style, the formation of a base for a new community (support, solidarity and symbiosis), and the like.[2)]

Next, illness is "a state in which one organ shows an abnormal variation and can no longer function normally."[3)]

Accordingly, as a deviation from the normal course of existence, illness is a state in opposition to health and it can be said that it is a continuous obstacle to the purpose of life, but it can also be said that "while both illness and health are natural conditions of life, isn't it rather the concept of illness that brings confrontation with death into sight?"[4)]

Furthermore, there is a tendency for modern medicine to regard "symptoms" as illness.

[3] The characteristics of medical care in the modern age.

The characteristics of medical care in the modern age are such that there is a tendency to lay the foundation in the natural sciences, and interest in the human and social aspects is weak. Recently, due to the appearance of variations in the structure of disease (malignant neoplasms, the emergence of adult diseases such as brain blood vessel and heart diseases, ailments particular to senility patients, traffic accidents, unfortunate accidents subject to workers' compensation, and the increase in psychotic disorders), the need for an understanding of human activities and the conditions of human life has at last been emphasized. Up to the present, the human and social aspects have been lost through neglect, and this increase in interest in these matters could be taken to be a sort of introspective and regretful reflection on the fact of this loss.

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2) Kyoichi Sonoda, et al., Anthology, *Changes in Health Views*, Tokyo University Press, 1995, P. 2–14.
3) Tomoaki Odan, *Humans in Illness*, Sun Route Nursing Training Center, 1989, P. 116.
4) Yasuo Okada, *Psychiatric Medical Care*, Keisoushobou, 1972, P. 179.

For example, Wilson has pointed out that the focus of medical science and medical care has been placed on technology, with attention fixed on mechanisms, techniques, tests and investigations, and computer processing. Due to this, he has also pointed out that the kernel of medical care, the supportive relationship and the mutual interaction between the physician and the patient, has often been forgotten.[5)]

Again, as another example, the introduction of specialization and new equipment for medical treatment in the field of clinical medicine has made it ever the more difficult for patients to respect the humanistic values, and protect their feelings and life style, and it must be considered that clinical physicians and doctors engaged in basic research are the main constituents of this problem. Of course, even though it is clear that innovations in treatment techniques are the motive power behind "progress" in medical treatment technology for hygiene and medical science, above all, medicine is regulated to a secondary position when confronted with illnesses and impediments beyond the power of modern medical science. This shows the importance of an expansion of the social welfare aspect of medical care (human rights consciousness). The development of "welfare medicine" is certainly important, and, with constant reflection and reconsideration of the human rights and theoretical problems involved in medical care, it would be most desirable to develop a revised type of medical treatment encompassing the whole body, a "comprehensive medical treatment."

However, when looking at modern medical treatment from an analytical viewpoint like this, and granted that price control and payment is guaranteed by medical-care insurance, the system is still essentially based on unrestricted diagnosis, treatment and management, a monopoly based on a free medical practice system and the theory of capitalism, and the principle of equality suffers when considering the opportunity for all of the citizens of the country to receive appropriate medical care.

In fact, the fundamental concept of the Japanese Medical Association includes "free treatment of illnesses, and the responsibility for this treatment lays within the members of the family." As long as this situation prevails, the concept of "social guarantees for medical care in modern society" will be neglected.

5) R. N. Wilson, *The Sociology of Health: An Introduction*, New York: Random House, 1970, P. 83.

Furthermore, when compared with those of all of the advanced countries, the Japanese ratio of the total expenditures for medical care to the GNP is the second lowest in the world, next to that of the United Kingdom, and roughly half of the ratio for the United States of America. However, while this figure is low, 30% of the total expenditures for medical care in Japan (27 trillion yen in 1995) is accounted for by medication, an indication of just how powerful the mechanism to sell medication is in Japan. The same figures for medical care expenditures for elderly citizens are lower by 30%. Furthermore, the number of beds in nursing attendant facilities for elderly citizens is the lowest among all of the advanced countries in the world and the home care system is extremely weak. Furthermore, and very characteristic of the Japanese system, while facilities will fight for new equipment for medical treatment, they are quite reluctant to spend money on increasing the number of staff members.

In this regard, reconsideration of the issues pertinent to the required guarantees for the health rights of the citizens of the country is essential. For example, it is necessary to reconsider measures such as efforts to control expenditures for medication and reallocate these funds for nursing attendant facilities for elderly citizens and perhaps measures to include nursing attendants for elderly citizens in the health insurance system, a "total health insurance" system.

II. Human Rights and Medical Care Issues in Modern Society

The following are examples of the kinds of medical care problems that Japan is facing now, i.e., issues related to:

1. Preventive hygiene and comprehensive medical care, 2. The formation of medical care guarantees, the system for payment of medical care expenses and national medical care programs for citizens, 3. Treatment for terminal cases and state-of-the-art medical treatment, 4. Chronic diseases, rehabilitation, and the supply system for medical treatment for elderly citizens, 5. Medical science education and the institutions for physicians, 6. Nursing and medical care system and hospital management, 7. Separation of medical and dispensary practice and pharmaceutical

education, 8. The use of and price standards for pharmaceuticals, 9. Environment, air pollution, traffic accidents and work-related injuries or deaths, 10. Reform movements for medical care, and 11. International and global medical care.

In addition, consideration of the issues related to medical care in the modern society from the cross-sectional viewpoint of human rights, welfare and ethics, brings us to the realization that the following five issues are vital. That is, issues related to; 1. Iatrogenic diseases or harm caused by the use of pharmaceuticals, 2. Physician-patient relationships and ethics, 3. Malpractice in medical treatment, 4. Life ethics and medical treatment in terminal cases, and 5. Health preservation care on an international scale.

[1] Iatrogenic disease issues (disease introduced by medical treatment or procedures)

a.) "Iatrogenic" AIDS issues

In Japan, where, instead of blood plasma treated by procedures based on cyroprecipitation and coagulation factor VIII, the use of imported condensed blood plasma for blood transfusions has caused HIV infection, i.e., iatrogenic AIDS, the major issues at hand are the lack of appropriate policies in the pharmaceutical industry and the willful use, on the part of the pharmaceutical industry and hospitals, of such treatment (raising the question of an intent to cause iatrogenic AIDS). Still another is the lack of efforts on the part of society to prevent such occurrences. Also, it is essential to develop sufficient measures in order to ensure privacy rights.

b.) Iatrogenic Solyibudin issues

Concurrent use of products in the Fluorouracil line of anticancer agents along with the antibacterial agent Solyibudin (US-BIL) has caused cases of blood disorders and this has brought several issues into public scrutiny, such as the general policy in Japan within the medical field of not informing cancer patients of the name of their disease. These cases have also brought out, among others, issues related to the fact that the pharmaceutical companies involved did not publish reports on the concurrent use of these medications and the issue of the responsibility of the Ministry of Health

and Welfare, which approved the use of the medication.

c.) Issues related to iatrogenic Smon Disease, caused by medication

Caused by the medication Chinoform, this disease was considered bizarre, and some patients were driven to suicide in the early days after its appearance. The issues at hand here are the public's disbelief in the country's policies for guarantees of safety in regard to medication and the structure of a pharmaceutical industry which can cause iatrogenic disease. Even by western standards (It takes poison to cure poison.), where it is often considered that an allowable amount of side effects must be taken into account, harm to health such as this cannot be either endured or allowed.

d.) Issues related to Thalidomide purchased at drugstores.

It took a full fifteen years for the causative factor of this incidence of iatrogenic disease to be determined and responsibility placed and recognized. Caused by medication sold in drugstores under the brand name of Thalidomide, this is another case where the lack of an once of prevention has caused a great tragedy.

e.) Issues related to iatrogenic disease caused by medication containing the essential amino acid L-Tryptophan.

This was the first case of iatrogenic disease caused by genetic engineering techniques in the manufacture of medication. There is sufficient concern that with the increasing demand for genetic engineering techniques, there will be an increasing number of such cases of iatrogenic disease involving such medication in the future.

f.) There are many other issues involving iatrogenic disease, such as cases where medication is administrated for long periods of time in large doses and also cases where the cause of the disease is still unclear.

In these cases, within certain limits for patients recognized as being victims of iatrogenic disease, there is a system in effect for payment of medical fees and retirement funds. However, the provisions provided by this system are quite insufficient. Furthermore, it is rather the mending of the type of medical philosophy that knows only "use medication" that is the first problem to be confronted.

[2] Issues related to ethics and the relationship between physicians and their patients.

In regard to the concept of "patient," Mr. Yonezo Nakagawa has said that "In general, the Chinese character for "patient" is at fault. It has two symbols of the mouth, with a pole laid on top, sealing them, placed over the symbol for the heart, so it means that one should not say anything from the heart. In English, the word can also mean 'bearing or enduring pain, difficulty, provocation, or annoyance with calmness.' Accordingly, the character means that one should be silent in front of a patient, and applies to a physician saying anything to a patient as well."[6)]

On reflection, we have come to the present with the uncontested thought that physicians have the power of life or death in regard to his patients. Even today, from the viewpoint that physicians have the power to determine that a person is ill and requires medical care, there is a tendency to regard physicians as having absolute authority in health matters, the paternalistic guardians of our health. The source of this concept is the esteem and reverence in which we hold these people, firm in the predominance of their specialized knowledge and technique, considered to be dedicated to dispensing love and compassion to the sick and suffering who come to them for relief.

Now, when considering physicians and ethics, it is perhaps useful to reflect on the concept of informed consent, which can be considered to be recognition of the rights of a patient. That is, this is the concept that there may be an inevitable change in the relationship between the physician and the patient due to changes in the structure of illness.

In other words, it is normal for patients to suffer from fear or anxiety about many aspects of their illness, both before they understand the explanation offered them, agree with or are convinced that the physician is correct in his opinion, or choose either their own course in regard to medical treatment or one offered to them. It is essential to obtain a patient-physician relationship that is ready to deal with treatment in a positive manner in order to relieve the discord in the patient's heart. Thus the patient has the right to live according to his own hopes and intentions, to con-

6) Heisei Patient Symposium, Yonezo Nakagawa, "Physicians will Change, Patients will Change", Medical Asahi, 1994, April Issue, P. 19.

duct his life, and ask for consideration in this matter, in such a fashion that medical care or treatment does not interfere with the quality of his life. For example, even if the physician tries to insist on what he considers the best measure to be taken, and the patient wants to stay within a certain limit dictated by his own values, it is the physician's duty to understand his patient's intentions and consider another measure that would be in agreement with the patient's life style (choice), and offer this choice to the patient. By no means is the physician the sole authority with the exclusive power to make all decisions in every case. On the contrary, he exists to conduct the "best measure," along with the patient, as seen from the patient's perspective.

Patients should not naively or totally accept "doctor's orders," but rather they should exercise their rights to receive proper medical treatment, so that they do not wind up crying in their beer over what should have been.

When looking at the various domestic and foreign chapters and verse regarding patient's rights for reference, it is evident that it is necessary for all parties concerned to produce original manuals explaining the subject clearly, a kind of "user's manual" on health rights.

Furthermore, it is extremely regretful, especially so in view of the trends of the times, that, in April of this year in a report by the Medical Care Council of Inquiry, an advisory organ of the Ministry of Health and Welfare, "Informed Consent" wound up being treated as a mere obligation due to resistance on the part of the Medical Association. The question here is whether this resistance on the part of the Medical Association was due to the interpretation that it would have only been a one-way duty that the association would have had to bear if it had been treated as a right, or perhaps, whether they considered that it would have meant little in the effort to gather points for medical treatment compensation insurance.

[3] Malpractice Issues

Accidents and mistakes occurring during medical care, or related disputes and trouble, are some of the most serious problems in the medical care crisis we are confronted with today, and it is safe to say that only the tip of the iceberg has been exposed to public scrutiny. In most cases, the patient has been left stranded, and it

is necessary to view these cases as hidden cases of obstruction of human rights. The number of iatrogenic disease cases, or cases of illness caused by mistakes in medical care, such as nervous disorders brought on by a careless word by a physician at the wrong time, is by no means small. When considering the damage due to such cases (any result of diagnostic methods or treatment that the physician would rather not have the patient aware of can be labeled an iatrogenic disease), referring back to the section above on informed consent should provide for a sufficient understanding of the problem.

Even if good results are obtained in medical care conducted in order to help the patient and these efforts have been conducted contrary to and despite the intentions of the patient, in the final analysis, the patient may take refuge in the fact that these actions are in violation of the principle of informed consent. Worries like this may well cause physicians to avoid tests, operations or treatment which include the risk of mistakes. However, protective attitudes like this, such as "keeping to moderate procedures will keep one from being legally responsible," can only harm or cause the loss of a physician's self-respect. Also, it is hard to say that this is a position based on considerations for the patients. Unlike the actual circumstances where physicians are on duty, or legally, we would like to have physician's feel totally responsible. That is, this sense of responsibility is required because a lot of the trouble stemming from mistakes in medical care (compensation for damages and legal penalties, etc.) occurs due to the fact that the relationship between the patient (or family) and the physician is not based on trust (human, heart-to-heart communication). The law and the courts are one possible course in resolving this kind of problem, but whether or not they are an essential course is a matter which requires mature deliberation. In other words, it may be considered that protective measures against malpractice problems related to medical care which are centered around legal recourse are just not sufficient.

What is important, in an "equivalent relationship between a patient and physician," is that the physician performs his duties totally as a professional in a position of responsibility. Only thus can the nature of the physician, with his specialized knowledge, and the right of the patient to choose his own course of action find a common meeting ground.

There are other important human rights issues to consider also, such as those related to the administration of justice and faults in court procedures or verdicts.

Thus, it is essential to proceed as quickly as possible with the establishment of an ombudsman system in order to deal with these kind of problems.

[4] Issues related to life and ethics.

In regard to cases where medical treatment which entails a great deal of pain is prescribed even though there is no hope of recovery, or where a patient is sustained by artificial means even though they are not conscious and are in a vegetable-like state, the problem becomes one of human dignity. That is, the issues at hand here are life-management medical care and the related ethics.

Now, in regard to dignified death, it should be recognized that the intentions and the will of the patient should be, by all means, respected, and the huge funds spent on medical care designed to prolong life (approximately 4 trillion yen yearly in Japan) should not be used as a reason to degrade this respect. At the root of this concept of decisions based on the will of the patient is the idea of reverence for life, the concept that life is sacred is essential. Studies on how to move scientific progress onto this decision base must be conducted. That is, for physicians and others in the field of medical care, not only is a standard to follow required for regulation as specialists, but it is also necessary, even essential, to develop new and improved social standards for medical care. Furthermore, it is also necessary to gather knowledge from fields other than medical science and medical care, and so that the profession does not stagnate, make the necessary changes required by the changes in the times and provide a structure for councils on ethics capable of sure decisions and stable regulation.

Incidentally, it is also necessary to make a distinction between brain death and dignified death, at least when discussing this subject. Brain death is that state where the brain has died but the heart is still functioning, and as it is now possible to use artificial respiration to keep the heart alive, this is an artificial state. In this regard, aside from making organ transplantation possible, there is no reason to recognize brain death as death itself.

Dignified death is respect for a natural death (facing death in a natural form and in a dignified, humane manner). In a vegetable state, even if a large portion of the

brain is dead, the nucleus of life, the nucleus, or root, of the brain is still alive. In these cases, disconnecting the life prolongation equipment will let the heart die, along with the nucleus of the brain. In addition to vegetable cases, many of the other cases where dignified death is a factor to consider are terminal cases of malignant cancer and cases of brain defects or obstruction in elderly patients.

Furthermore, in regard to the position that physicians should take in cases of euthanasia or dignified death, and considering the actual situation in America and Holland, the main point is that no one doctor should make such decisions alone, but rather he should consult with other physicians and consider their viewpoints. Dignified death should be placed in a position above informed consent on a line extended from that concept's respect for the intentions of the patient.

Thus, it is necessary to grasp the proper form of medical care adapted to the new age, and go on to realize a new type of bioethics (life ethics) which matches the character of the times. Then, based on this, it is necessary to have studies on life styles, health, welfare and industry, etc., (human studies) included in the medical profession's educational system. As a result, this will allow for a meaningful rapport between patients and physicians (interpersonal communication on a deep level) and also for the development of medical care which includes a common sense of both parties as living beings working together toward a common cause, saving life. Here, it is most important to first raise a generation of physicians who have acquired an education in the humanities, as well as in the medical science aspects, doctors who can apply this knowledge in clinical therapy and diagnostic medicine. That is, we must raise a generation of physicians who are full of human love and compassion and who are conscious of life philosophy.

The following items, pointed out by Mr. Nakagawa, are useful for reference in this regard. That is, he has suggested that "It is especially in the field of medicine where one is inevitably confronted with extremely serious situations, such as death and pain, and it is not enough to have an intellectual understanding of these matters, but rather it is maturity of character that is required. Then, in order to provide this, it is not enough to develop and employ scientific training methods, but rather haste is required in the development of training methods in the social and culture aspects."[7] It is necessary to include this subject of "Medical Ethics," taught well and certain,

in the medical profession's educational system.

Recently, a new philosophy has become evident, called "Living Well," which includes a written definition (signed by the person involved) of one's intentions (self-determined) in regard to how one intends to die, based on the following three items; 1. Refusal of life prolongation equipment even when facing the terminal stages of an incurable disease, 2. Request the use of pain killing medication and treatment even if this hastens death, and 3. The demand that life prolongation and maintenance equipment not be employed if one falls into a vegetable-like state. This does not include the use of medication to wilfully take ones own life (freewill euthanasia). This concept, aside from the use of artificial pain-killing equipment, stresses a natural death. The question of whether natural death (dignified death) should be incorporated into the laws of the land will certainly be the subject of much debate, and let it be so. The "Living Well" concept is an important issue because it stresses a relationship of trust between the patient and the physician.

However, it seems that dignified death as specified by the Japanese Dignified Death Association (originally the Euthanasia Association) cannot be called euthanasia in Holland (the most progressive country in this regard).[8)]

[5] Issues related to medical care for terminal cases.

During the most important period on the balance sheet of human life (during the last three remaining months of life), comprehensive patient care (for example, relief from pain during the progression of cancer with metastasis) is the epitome of putting human rights into practice. In the midst of the health boom in society, with so many people believing in health for health's sake (people with the philosophy of not thinking of death as much as possible, and who also overly rely on and believe in medical care), the following points are very important.

a.) Methods employed to inform a patient of his disease and problem points.

While the question of how to inform a patient that he or she has cancer is an

7) Yonezo Nakagawa, *The Life of Learning*, Kosei Shuppansha., 1993, P. 178.
8) Kazuo Ota, et al., Anthology, *The Practice of Informed Consent and Verification in the Diagnosis and Treatment of Cancer*, Sentan Igakusha, 1994, P. 161.

extremely important matter, the general case in Japan is such that there are no discussions on alternatives, and the patient is most often left to come to the proper conclusion with the passage of time, without being actually informed.

In general, as a basis for determining if it is necessary to inform the patient or not, it is considered necessary if there is enough margin for the patient to make sweeping changes in his or her plans and expectations for the future. That is, if there is the possibility that the quality of life during the remain time left to a patient will improve due to being informed, and if the act of informing the patient "stimulates the process of advance toward perfection as a human being" after being informed, then it has been said that this act holds a vital meaning.[9)]

Also, it has been said that the reason that the percentage of cases in Japan where the patient is informed is so low is the inadequacy of the medical care support system for these kind of patients after they have been informed. In the future, because more and more patients will demand to be informed of the real facts of their cases, development of patient-physician relationships and teamwork systems which can respond adequately to the demands of the times will become most compelling.

b.) Issues related to life prolongation and excessive care.

We are now living in an age where, technically, it is possible for medical science to prolong life for quite a long time. For this reason, this has been called the medical treatment of death. However, this subject is characteristic in that it is not common to discuss whether or not this kind of treatment should be considered to be excessive. Furthermore, when this kind of treatment is conducted for the economic benefit of the medical care system or the pharmaceutical industry, no opportunity exists to place a limit on the length of the treatment and it becomes intensive and even excessive care. In the end, it is only when there is a very strong desire on the part of the patient, the immediate family and other relatives for life prolongation, when they consider it irreplaceable, that this kind of treatment should be considered.

c.) Medical care for terminal cases in medical facilities and problems.

9) Yujiro Ikemi, et al., Anthology, *Japanese Terminal Care*, Seishinshobou, 1989, P. 4–5.

In Japan, the number of people who would prefer to meet their end at home but who wind up facing death in the hospital is increasing (60% overall and 85% for cancer patients). However, the bigger the hospital is, the less communication there is between the physician and his patients, and it has been said that there is a stronger inclination to use such so-called life prolongation medical care in such large institutions. In this sense too, there is a clamor for home care with a local "family doctor" in charge.

d.) Medical care for terminal cases at home and problems.

Some investigations have shown that about 80% of terminal case patients (72.4% in general and 84.3% of the elderly) would prefer to have their "death at home." The main reason that people must face death in the hospital is that the home care system is insufficient.[10)]

There are many problems to resolve in home care, specialized sick rooms, assistants, high priced equipment, the lack of volunteers, and the difficulty of maintaining contact with the physician in charge of the case.

Also, for modern man, who has forgotten how to watch the approach of death or nurse a person throughout the process, it presents a problem in that death seems ominous, and it would seem that there is a sense of resistance to let death occur at home.

e.) Education to raise consciousness regarding death and life.

As education in matters related to death, grief, and an understanding of human nature, the study of death should lend motivation to the study of the dignity of life and the significance of daily life. Building human relationships based on a reverence for life is most important, and it is only when someone has considered his own life that he can relate in a meaningful way with the death of another person. Humans develop continually until the moment of death, and medical care which allows for the coexistence of people on the way to death and this aspect of humanity, growth, is vital.

10) Yujiro Ikemi, et al., Anthology, *Japanese Terminal Care,* Seishinshobou, 1989, P. 5.

f.) The relationship of religion to terminal cases.

It has been said that it is desirable to arrange matters so that the patient has help in considering the meaning of life and death and how to go through the changes involved, without pushing religious faith on a person, and to respond to his or her desires, while taking care to fulfill the needs of the patient.

It is important to provide assistance which will make it possible for the patient to become aware of the eternal quality of life (a view of life based on the trust in the world of life beyond that of the material body). That is, what is needed is education related to death which will be the purest education during the course of life, and it can be said that this kind of education could be the base from which one could perfect himself as a human being. A view of life and death like this should allow one to open the door to a full and characteristic life, one accompanied by harmony between oneself and others based on a reverence for life.[11)]

In any case, it is necessary that matters be arranged so that the patient can meet death in a peaceful manner, and if the patient wishes religious help, then it is necessary to make it possible for them to receive it .

[6] International health care issues.

As examples of the life threatening international health care issues we are faced with today, such as malaria and Kala-Azar in former years, there are carcinomas resulting from human-retro viruses (RNA tumors), AIDS due to HIV (human immunity failure virus) infection, the killer virus Ebolla, and starvation problems in various countries. Emergency measures to meet these crises on an international level are essential.

Next, looking at the results of an investigation conducted by the European branch of WHO from 1970 to 1983 on trends toward legalizing patient rights and related regulations, we can point out the following items.[12)]

1. Almost all of the countries in Europe lack laws covering the rights of patients.

11) Yujiro Ikemi, et al., Anthology, *Japanese Terminal Care,* Seishinshobou, 1989, P. 1–14.
12) Masateru Kawano, *A Change in Order* (Mitsuru Ikenaga, Anthology, *Patient Rights*, Kyushu University Press, 1995 Issue), P. i–v.

2. Privacy rights and rights governing access to patient records (secret retention and information) have come to be widely accepted.
3. It has come to pass that it is considered that the duty of physicians to protect the privacy of their patients now means that physicians have a right to keep records secret.
4. A trend to introduce new processes for complaints has started in Europe in order to protect the patients.
5. An increase in legislation related to regulations governing experiments involving humans has been evident since 1970.
6. In regard to mental patients who have been forcefully hospitalized, self-determination rights have been the subject of scrutiny and new legislation is being considered.
7. In regard to mentally handicapped patients, a trend has been seen in which new civil laws have been introduced, moving from the old incompetence system to a new guardianship system.

Furthermore, in the same investigation conducted from 1988 to 1989, interest in patient rights demonstrated an increase on several levels, indicating dynamic development in this area.

In regard to the state of affairs in our country, Japan, especially regarding health and medical care for resident foreigners, it cannot be forgotten that the situation is serious.

[7] Other health care issues worthy of special note.

Although this also applies to several issues related to welfare medical care, in regard to patients with incurable diseases, or those with extremely difficult to treat diseases, problems have been handled by the social welfare system, and problems related to the seriously mentally handicapped have been handled first by the educational system and then by the psychology authorities. Medical care has taken a secondary position. Also, as an example, the medical academy has been very late in dealing with workers' compensation insurance and Minamata Disease. In this sense, attention should be concentrated on the fact that it has been a strong conscious-

ness of human rights (based on welfare philosophy) that has promoted resolutions to this kind of problem.

Furthermore, we are faced with the problem of how to ensure that the standards of medical care for the elderly generation do not fall to such a low level that they are regarded with discrimination (especially guarantees of health rights for elderly women with dementia). In addition, we are also faced with the problem of abortion and its relationship to health rights and the problems associated with birth.

Sufficient vigilance is also required in regard to intrusion of privacy rights and discrimination due to the advances that have been made in genetics, which have made it possible to clarify genetic background.

As we have seen in the sections above, the issues characteristic of our modern society are the safety of medication developed through genetic engineering, the question of whether or not and how to inform patients that they have cancer, organ transplants, exogenous insemination (including birth in a substitute mother), and whether choosing the sex of a child through genetic engineering should be allowed or not, as well as other human rights and ethics issues.

The possibility that there are "experiments which are intrusions of human rights" being conducted in the name of medical science is quite worrisome. In regard to this problem too, it is most desirable to provide some form of protection. For example, there was a case in America where a black man with syphilis was not treated but just observed (1932–1972). The atrocities which occurred during the Second World War in Nazi Germany and the Japanese experiments on living bodies cannot be forgotten either. That is not to say that all experiments on living bodies and autopsies should be criticized as immoral acts. In America, a presidential advisory committee was formed in 1980 to supervise regulations for experiments on human beings.[13] Since then, we have seen more patient rights being protected and more cases where self-determination and informed consent have been respected. In the final analysis, it can be considered that medical care ethics start with the establishment of the custom of adding the protection of informed consent to established methods of treatment, and with respect on the physician's part for the intentions and choice of the

13) Keiko Nakamura, *A Reconsideration of the Ethics of Medicine* (Koichi Bai, Anthology, Ethics of Medicine), Nihon Hyoronsha, 1987, P. 105.

patients (determination).

Furthermore, while the main point in the background of this subject of ethics related to medical care lays in the increase in the significance of patient rights, it should not be forgotten that the level to which patient rights will be protected and maintained is a reflection of the level of democracy in that country.

III. The Human Perspective in Modern Medical Care

Mankind suffers from anguish brought on by the pain of illness (physical pain brings on mental anguish and vice versa), and it has been said that this anguish, passive and rational in nature, destroys the human aspects of daily life, causes the worry that there will be an influence on those in the surroundings, and further that it is related to the fear of death.

From a medical standpoint, people are the subject of other people's attention, care, and concern. In addition, patients are exposed to danger and are extremely weak and fragile. Accordingly, they are deserving of protection, compassion and efforts made to relieve their anguish. Ideally, a physician should apply all of his technique and knowledge intelligently, focusing it on attention to the patient and the treatment. In other words, the establishment of the ability to feel both the pain of the patient and compassion toward them, and the ability to mitigate or cure this anguish depends on the humanity of the physician.

Thus, after due consideration of the present state of affairs, we find that modern man cannot even be born or die in a natural manner and during his lifetime he is left to anguish in the midst of an abyss when it comes to the question of what is a true ethical standard.

In the fields of health and medical care, the subjects of this study, even though the most important objective is to provide protection for a human-like, anguish free, and safe life, medical technique and science has bound itself to the capitalistic economic faction and drawn humans into a valuation system based on materialism. Thus, we humans are being viewed in an inhuman manner.

As long as the situation is leaning toward what could be called "quantity of life"

(amount of life), we stand in danger of losing the value of "quality of life" (QOL). That is, we are seeing a trend where a human-like life style is impossible, for example, cases where patients are tied to and kept alive by tons of life support equipment, unable to even communicate with their family. Are we thus bound to change such that we cannot live out our precious lives to fulfillment?

The comments that Mr. Masao Fujii has made are rich with suggestions related to this subject. That is, he has pointed out that "It can be said that the fact that medical science has treated humans in an emotionless manner and treated them as objects is one factor which has contributed to the progress we have seen so far."[14]

According to Mr. Junichiro Hironaka, "The interest of physicians is now strongly leaning toward patients who may become recipients of organ transplants and transplant donors have been placed in the category of objects, mere treatment resources."[15]

Also, Mr. Nakagawa, mentioned above, has said that "To understand humans is to understand diversity, and we must be conscious of the fact that being understood is, in this human world, most important."[16]

Conclusion

Clear from the considerations above, it can be considered that in order to establish a true human perspective, the patient-physician relationship (human-like communication) must first be based on the self-determination rights of the patient. On reflection, a proper evaluation is required of the role that patients themselves have played in the progress of medical care and medical science. Furthermore, it is necessary to conduct sufficient studies and obtain confirmation of the results, in regard to the various related human rights issues. At the same time, we cannot overlook the contributions and services rendered by those in the nursing profession, the "female" nurses.

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14) Masao Fujii, *Religion of Human Relationships* (Kazumasa Hoshino, Anthology, *Life Ethics and Medical Care*), Maruzen, 1994 Issue, P. 7.

15) Junichiro Hironaka, *Medical Care and Human Rights* (Todai PRC Planning Committee, *Brain Death*, (Inc.) Technique and Humans, 1986 Issue) P. 163.

16) Yonezo Nakagawa, *The Life of Learning,* Kosei Shuppansha, 1993, P. 178.

It can be said that, where things have gone wrong is that the "human perspective," which should take the form of "benevolent techniques and acts of healing," has actually assumed the form of a "Calculating technique." Also, for example, during cases of misses in medical care (disputes or trouble in medical affairs) or cases of harm due to medication, our greatest wish is for the kind of physician or researcher who will take the side of the patient and provide testimony, advice and his or her expert opinion.

Thus, we have come to realize anew that "expansion of human rights" and the "establishment of a welfare philosophy" are extremely important as principles stemming from the original purpose of medical care (to free humanity from the anguish of disease). It is our heartfelt prayer that the influence of religion in all of the various countries in Western Europe will bring about a higher philosophy regarding human rights which will stem the trend towards materialism, and that a higher level of human rights consciousness and welfare philosophy will still the storm raging over health preservation and medical care, and become the motive power of a revolution which will bring about the "human perspective" in medical care which is so drastically required, a "humane perspective."

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